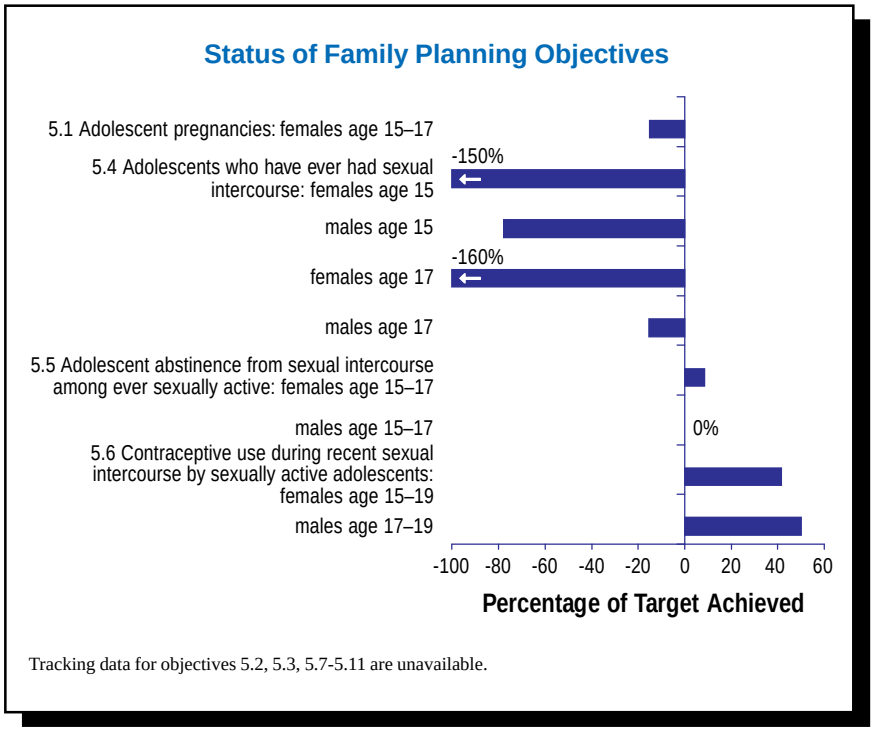
5 Family Planning



Tracking data for objectives 5.2, 5.3, 5.7-5.11 are unavailable.

Lead Agency: ***Office of Population Affairs***

FAMILY PLANNING

Family planning provides individuals with the information and services they need to make informed choices about whether and when to become parents. Family planning services include counseling and medical services that are important determinants of the health and well-being of individuals, particularly women, and of healthy pregnancies. HEALTHY PEOPLE 2000 targets have been set to reduce the incidence of adolescent pregnancy, to increase the numbers of teenagers who delay sexual activity until they are older, and to increase the use of contraception by all women at risk of unintended pregnancy, including adolescents. Whether seeking to avoid unintended pregnancy or to prevent the spread of sexually transmitted diseases, family planning objectives are critical priorities for the Nation.

Teenage pregnancy involves health, educational, and social welfare issues. So far, only limited success has been realized by concerted attempts to reduce pregnancy rates among adolescents, to convince teenagers to delay sexual activity, and to reduce repeat pregnancies among this age group. Because of the serious social and economic consequences of early childbearing, both on adolescent parents and their babies, family planning deserves renewed attention and unqualified support. Family planning needs to be a cornerstone service of adolescent health care, with a link drawn to other risky behaviors of youth, and should do what the name suggests—help individuals plan their families.

It is estimated that if subsidized family planning services were not available, between one and two million additional unintended pregnancies would occur each year. Other estimates show that for every dollar invested in family planning, $4.40[1] in welfare and medical service expenditures is avoided.

With access to family planning, adults can plan the number of and space the intervals between children. Research showing that low birthweight may be linked to insufficient spacing between children reinforces the importance of ensuring such access.

Review of Progress

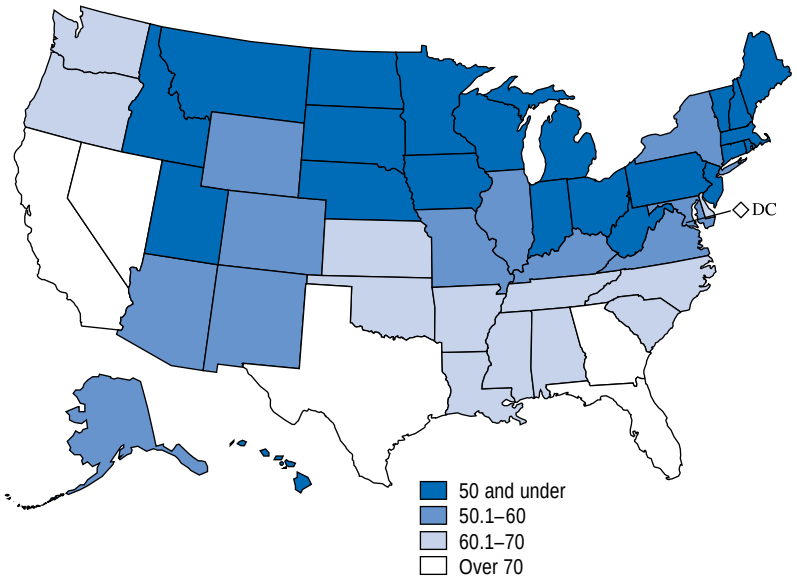
The data used to establish baselines for the initial tracking of the family planning objectives are from the 1980s. In 1988, 67 percent of all women aged 15–44 were considered to be at risk of unintended pregnancy; the proportion not using a contraceptive method was approximately 10 percent. Even this apparently small proportion is important—in absolute numbers this means an estimated 4 million women were at risk of unintended pregnancies. The proportion not using a method of contraception is even higher among some population subgroups. Only 85.3 percent of women whose income fell below 200 percent of the poverty line and only 80.2 percent of the women below 100 percent of the poverty line used contraception in 1988. Thus, nearly 20 percent of the Nation's lowest income women at risk of unintended pregnancy used no form of contraception. Among poor teenagers, the proportion was 25 percent.

Data for the early 1980s show that among married or cohabiting women aged 20–29 and 35–44, use of any method of contraception was somewhat lower in the United States than in other developed countries. In the United States 68 percent of married or cohabiting women aged 20–29 use a contraceptive method, compared to 76 percent in Greece and the Netherlands, 73–74 percent in Finland, France, Norway, and Portugal, and 72 percent in Italy and the United Kingdom. Even larger differences exist among women aged 35–44, with about 63 percent of this group using a contraceptive method in the United States, compared to 75–83 percent in a number of European countries, including all those listed above as well as some others.[1]

According to the National Survey on Family Growth, the proportion of adolescent females aged 15–17 who are sexually experienced increased from 29 percent in 1970 to 52 percent in 1988. Among males aged 17–19, the proportion sexually active increased from 66 to 76 percent between 1979 and 1988 according to the Survey of Adolescent Males. Data from the Youth Risk Behavior Surveillance System (YRBSS) also show increases in sexual activity. Among 15-year-old females, 27 percent reported being sexually active in 1988 compared with 36 percent in 1991. For 15-year-old males, 33 percent reported being sexually active in 1988 compared with 44 percent in 1991. Among 17-year-old females, 50 percent reported being sexually active in 1988, compared with 66 percent in 1991. For 17-year-old males, the proportion sexually active was 66 and 68 percent, respectively, in 1988 and 1991.

Sexual initiation is occurring at younger ages: young women aged 15 show the largest increase in the proportion sexually active—from slightly less than 5 percent in 1979 to nearly 26 percent in 1988. Age at initiation of sexual activity is important because when first intercourse is early, contraceptive use is lower and pregnancy risk higher. Younger black women are more likely to be sexually active than their white counterparts. The difference between the two races is narrowing; however, the increases in adolescent sexual activity observed during the past decade are much greater for whites.

Objective 5.1: *Reduce pregnancies among females aged 15–17 to no more than 50 per 1,000*



Source: CDC/NCHS, Vital Health Statistics, 1991

Efforts in the United States to prevent adolescent pregnancy have taken a number of forms—sex education,

abstinence education, life skills education, contraceptive education, and contraceptive services programs—both singly and in combination. During the past decade, the primary Federal focus to prevent adolescent pregnancy has been abstinence education. Despite the requirement that such programs be evaluated, there is little evidence of their success or failure—with the exception of apparent increases in knowledge among those who participate in the programs.

Fewer than 10 percent of children receive comprehensive sexuality education programs.[2] "Youth at Risk," a report by Population Action International, a nonprofit family planning advocacy group, concluded that the school systems of most countries have largely failed to meet the sexual health education needs of youth. The reasons: societal discomfort in acknowledging adolescent sexual activity and the misconception that access to sexuality education or contraception promotes sexual activity among youth. A report by the World Health Organization stated there is no evidence that sex education in schools leads to earlier or increased sexual activity among young people. The review of 35 studies indicates sex education is most effective when given before a young person becomes sexually active and programs that promote both postponement of sex and protected sex are more effective than those that promoted abstinence alone.[4]

In its 1993 assessment of State sexuality education programs, the Sex Information and Education Council of the United States (SIECUS) found 48 States either recommend or require sexuality education through State law or policy (38 States have developed State sexuality education curricula). SIECUS also found that sexuality education most typically falls under health education; only 24 States have an identified staff person who is in charge of sexuality education; only 9 States require specific training as a condition of teaching sexuality education; and only 14 States require sexuality teachers to be certified in a specific field. Thirty States have school/community advisory committees to develop, review, or recommend appropriate sexuality education materials and concepts to be taught at various grade levels.[3]

Three relatively new sexuality education curricula have shown promising results with respect to delay of sexual activity as well as increased contraceptive uses when sexual activity is initiated.[4,5,6] All three programs include information about sexuality and contraception, as do most traditional sexuality education programs. The important difference is that they also include training in decisionmaking and resistance skills, and practice in applying those skills. These programs appear to be more effective with younger adolescents and with those who have not yet initiated sexual activity, providing support for the argument that sexuality education should begin earlier than currently is the norm. Another study has shown that young men who reported receiving instruction in resistance skills had lower rates of sexual activity than those who did not receive such instruction.[7]

The proportion of young people who choose abstinence has increased. In 1988 an estimated 23.6 percent of ever sexually active females, aged 15–17, abstained from sexual intercourse. In 1991, 25 percent abstained from sexual intercourse. Among

adolescent males, the percent increased from 33 percent in 1988 to 36 percent in 1991.

Counselors and educators should be trained in building skills to help young people who choose abstinence to sustain their choice. Educational materials and counseling should give credence and support to abstinence as a healthy choice. Peer groups advocating abstinence also should be encouraged. The consequences of nonmonogamous sexual intercourse can include elevated risk of acquiring one or more sexually transmitted diseases (STDs), including HIV infection. In addition, some STDs have lasting negative effects on fertility. Therefore, abstaining from sexual intercourse is a preferable prevention choice, especially for adolescents.

Among sexually active adolescents, contraceptive use has increased, as measured by use of a contraceptive method at most recent intercourse. For females aged 15–19, 78 percent used contraception in 1988, compared with 81 percent in 1991. For high school males, contraceptive use at most recent intercourse increased from 78 percent in 1990 to 83 percent in 1991.

Despite increases in abstinence and increased use of contraceptive methods, adolescent pregnancy rates have increased. In 1985, the pregnancy rate for females aged 15–17 was 70.9 per 1,000 females; in 1990 the rate was 74.3. Over this same time period, live births for this age group increased from 31 to 37.5 per 1,000 adolescent females, while abortions declined from 30.6 to 26.5 per 1,000 adolescent females. Fetal losses account for the remaining pregnancies. Among black teens 15–17, the pregnancy rates increased from 134 to 140 per 1,000 black females between 1985 and 1988.

A 1992 Primary Care Providers' Survey provides a picture of the extent to which clinicians are routinely inquiring (of 81–100 percent of patients) about family planning for females of childbearing age or providing counseling about family planning. Among pediatricians, 18 percent reported that they routinely inquire about family planning, while 36 percent reported that they routinely counsel about family planning. For other providers the findings were: family physicians, 28 percent and 36 percent; obstetricians/gynecologists, 48 percent and 65 percent; nurse practitioners, 53 percent for both.

No data beyond the baseline are available to track unintended pregnancy, infertility, failure of contraceptive method, family discussion of human sexuality, information from counselors, and clinic services for HIV infection and STDs. The data for tracking most of these objectives will be included in the 1995 cycle of the National Survey of Family Growth. The 1994 cycle of the National Survey of Adolescent Males will provide information on a population of in- and out-of-school males aged 15–19. In the interim, information from CDC's Youth Risk Behavioral Surveillance System provides useful tracking data, although this biennial survey only captures in-school youth.

1995 Revisions

A new objective was added to track the use of contraception by women at risk of unintended pregnancy. The objective is aimed at increasing to at least 95 percent the proportion of women (aged 15–44) at risk of unintended pregnancy who use contraception. Special population targets for low-income women seek to narrow the gap between poor and nonpoor women who use contraception.

Objective 5.1 has been revised to focus on females aged 15–17 because the consequences and implications of pregnancy are most severe for adolescents. The number of pregnancies to adolescents under age 15 is small, making it difficult to measure trends. Adolescents over age 17 are considered legally to be adults. The consequences of unintended pregnancy among females aged 15–17 and the implications for their children's lives are long-lasting. In objective 5.6, the age groups also have been modified to measure the proportion of sexually active, unmarried people aged 15–24 (measured in two age groupings: 15–19 and 20–24) rather than just adolescents aged 19 or younger. The objective has been expanded to measure the 20- to 24-year-old population because unprotected sexual intercourse puts many of these young adults at risk of unintended pregnancy, STDs, and HIV infection.

Special population targets were added to several objectives. A Hispanic subobjective was added to objective 5.2. Black males aged 15, black males aged 17, and black females aged 17 were established as special population targets for objective 5.4 to reduce the proportion of adolescents who have engaged in sexual intercourse.

The target in objective 5.7 was adjusted proportionately to a new baseline. The objective tracks the percent of women rather than couples who experience pregnancies despite the use of a contraceptive method. Black and Hispanic special population targets have been established for this objective.

The scope of objective 5.9 has been expanded to measure the proportion of family planning counselors who offer to their patients with unintended pregnancies balanced, complete, and accurate information about all pregnancy options, including prenatal care and delivery, infant care, foster care, adoption, and pregnancy termination. The provision of information on only one option is not sufficient for a patient to make an informed choice. The revised objective is a more appropriate measure to assess the extent of counseling services offered by public health professionals in family planning settings.

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